MARYLAND STATE DEPARTMENT OF HEALTH

00100

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O. LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 33 Johnson Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena. P.O.
STREET ADDRESS (If rural, give location) 33 Johnson Road

3. NAME OF DECEASED (Type or Print) (First) Agnes (Middle) 7 (Last) Aacs
4. DATE OF DEATH (Month) January (Day) 25 (Year) 1950
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH April 2, 1880
9. AGE last birthday 69 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Washington, D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME John Johnson
14. MOTHER'S MAIDEN NAME Mary Cline
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY No.
17. INFORMANT Mrs. Anna T. Thomas

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Homicide - 2 bullet wounds through head - 38 caliber.

981

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

166

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☑, undetermined ☐.*

SIGNATURE John M. Coffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 1-26-50

23. BURIAL, CREMATION REMOVAL (Specify) Cremation
DATE THEREOF 1-27-50
NAME OF CEMETERY OR CREMATORY Laudon Park
LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG. 12/27/50
REGISTRAR'S SIGNATURE L. J. De Albon
24. FUNERAL DIRECTOR Thomas W. Singleton. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 30 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00101

Reg. Dist. No. 20

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Edgewater - LENGTH OF STAY (in this place) 2 1/2 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS - Edgewater P.O., Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Edgewater, Md.
STREET ADDRESS (If rural give location) Edgewater P.O.

3. NAME OF DECEASED (Type or Print) (First) Frances (Middle) Daywalt (Last) Ainsworth.

4. DATE OF DEATH (Month) 1 (Day) 20 (Year) 1950

5. SEX F
6. COLOR OR RACE W
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH July 21, '76
9. AGE last birthday 73 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) —
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Leitersburg, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Samuel Daywalt
14. MOTHER'S MAIDEN NAME Eliz. Dinsmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17. INFORMANT Daughter - Mrs. A. Gordan Fleet

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	2 1/2 days
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Hypertension	1 yrs —
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1/18/, 1950 to 1/20/1950, that I last saw the deceased alive on 1/20/, 1950 and that death occurred at 12:15 p.m., from the causes and on the date stated above.

SIGNATURE Frank M. Shipley (Degree or title) MD. ADDRESS 63 College Ave Annapolis, Md. DATE SIGNED 1/20/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 1-20-50
NAME OF CEMETERY OR CREMATORY MORELAND MEMORIAL PARK
LOCATION (City, town, or county) TOWSON, Md. (State) —

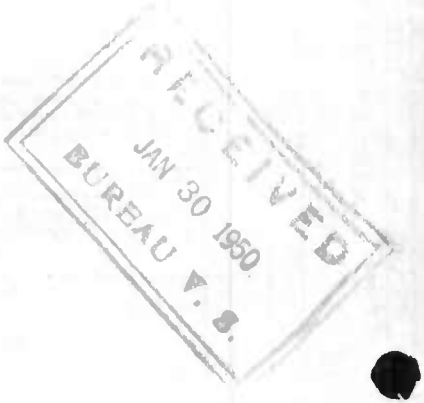
DATE REC'D BY LOCAL REG. 1/23, 1950
REGISTRAR'S SIGNATURE Edward Collinson
24. FUNERAL DIRECTOR B. L. HOPPING & SON ADDRESS ANNAPOLIS, Md.

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15


RECEIVED
JAN 30 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00102

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 25

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn. LENGTH OF STAY (In this place) 8 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 301 - Audrey Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland - COUNTY -
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn. B.C.
STREET ADDRESS (If rural, give location) 3719 - Second Street. - ✓

3. NAME OF DECEASED (Type or Print) (First) Joseph (Middle) Frederick (Last) Anderson Jr.
4. DATE OF DEATH (Month) Jan. (Day) 28 (Year) 1950
5. SEX Male
6. COLOR OR RACE White
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~ (Specify) married
8. DATE OF BIRTH 10/7/1893
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk in a grocery store
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Albert Anderson
14. MOTHER'S MAIDEN NAME Hannah Hoff.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1915
16. SOCIAL SECURITY NO. 215-05-7725
17. INFORMANT Mrs. J. F. Anderson (wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion	Sudden.
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Enlarged heart	?
95 c	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustave H. Paulsen M.D. (Degree or title) assistant County Med. Examiner ADDRESS Glen Burnie, Md DATE SIGNED 1/28/50

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL
DATE THEREOF 1-31-1950
NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.
LOCATION (City, town, or county) A A Co (State) MD
DATE REC'D BY LOCAL REG. 1/30/50
REGISTRAR'S SIGNATURE H.W. Hedrick Dm
24. FUNERAL DIRECTOR Bernard E. Harle ADDRESS 121 E. West St

266-61

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00103

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Maryland
LENGTH OF STAY (in this place) 33 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Connecticut COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New London
STREET ADDRESS (If rural, give location) 95 Federal Street

3. NAME OF DECEASED (Type or Print) (First) JON (Middle) WAYNE (Last) ARTURI

4. DATE OF DEATH (Month) January (Day) 11 (Year) 1950

5. SEX Male

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH 12-9-49

9. AGE last birthday ------- yrs. If under 1 year: Months -/- Days 33 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child

10b. KIND OF BUSINESS OR INDUSTRY Child

11. BIRTHPLACE (State or foreign country) Maryland, Balto. city

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Theodore Arturi

14. MOTHER'S MAIDEN NAME Nancy Resh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Premature birth, Neonatal death	33 days
774.5 Antecedent cause(s)		
107 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Broncho pneumonia	3 days
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-9, 1950, to 1-11, 1950 that I last saw the deceased alive on 1-11, 1950 and that death occurred at 12:40 A.m., from the causes and on the date stated above.

SIGNATURE E. R. MOELLER (Degree or title) CDR., MC, USN ADDRESS USNH, Annapolis, Maryland DATE SIGNED 1-11-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 1/13/50 NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery LOCATION (City, town, or county) (State) Baltimore, Md.

DATE REC'D BY LOCAL REG. Jan 12-50 REGISTRAR'S SIGNATURE A. W. Hedrick

24. FUNERAL DIRECTOR HENRY SANDER & SONS, INC. ADDRESS BALTIMORE - 13, MD.

1 - 1 - 12/9/49 - 00 - 1 - 28 - R

49 - 28657

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

60164

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills P.O; LENGTH OF STAY (In this place) 3 years; HOSPITAL OR INSTITUTION OR STREET ADDRESS Defense Highway

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gambrills P.O.; STREET ADDRESS (If rural, give location) Defense Highway

3. NAME OF DECEASED (Type or Print): (First) RUSSELL (Middle) C. (Last) BARTGIS

4. DATE OF DEATH: (Month) JAN. (Day) 6. (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 12 1886

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A

13. FATHER'S NAME: Charles H. Bartgis

14. MOTHER'S MAIDEN NAME: Annie E. Alexander

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Agnes E. Bartgis Gambrills Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: Sudden

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 940 (b) Coronary Sclerosis — unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claff M.D. Deputy Medical Examiner Annapolis Md. 1/6/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: 1/9/50; NAME OF CEMETERY OR CREMATORY: Oak Lawn; LOCATION (City, town, or county) (State): Eastern Ave Extended

DATE REC'D BY LOCAL REG.: Jan 9-50; REGISTRAR'S SIGNATURE: C. St. Hopkins

24. FUNERAL DIRECTOR: Wm Cook Inc. ADDRESS: 1217 St Paul St.

60297

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00105

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Edgewater
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN:
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First) Jennie (Middle) (Last) Brown
4. DATE OF DEATH (Month) Jan (Day) 22 (Year) 1950
5. SEX: FEMALE
6. COLOR OR RACE: COL.
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 1 1878
9. AGE last birthday: 71 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Murray
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT AND ADDRESS: Nellie Isaac Edgewater

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chronic Myo Carditis — 3 weeks

422.1 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arterio-Sclerosis

(c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify):
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 3, 1950, to Jan 22, 1950, that I last saw the deceased alive on Jan 22, 1950, and that death occurred at 9:30 A. m., from the causes and on the date stated above.

SIGNATURE: R.L. Richardson (Degree or title) M.D. ADDRESS: Ann Arundel DATE SIGNED: Jan 23, 1950

23. BURIAL, ~~CREMATION~~ ~~REMOVAL (Specify)~~: BURIAL. DATE: Jan 25-1950 NAME OF CEMETERY OR CREMATORY: DANIEL STAR CEM. LOCATION (City, town, or county): WEST RIVER (State): MD

DATE REC'D BY LOCAL REG.: Jan 24, 1950 REGISTRAR'S SIGNATURE: Edward Collenson
24. FUNERAL DIRECTOR: T.G. Sandusky & Son Galesville ADDRESS: MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 30 1950
BUREAU T. L.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00166

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH · COUNTY: Anne Arundel · MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland · COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RURAL Glen Burnie · LENGTH OF STAY (in this place): 3 years.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, - Glen Burnie
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hodges and Bell Avenue	STREET ADDRESS (If rural give location): Baltimore Bell Avenue Shoreland.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CHARA	REBECCA	BURCH	JANUARY	1	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
F	W		July 6, 1869	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Baltimore Md	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles H. Richl	Catherine Blocke

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No.	none.	Charles J. Burch, Son

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Arteriosclerosis, general	years.
422.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Cardio-Vascular Disease	"
(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Gangrene of right foot	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11/28/49	Gangrene of right foot	Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
None.				

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 11/28, 19.49, to 1/1, 19.50, that I last saw the deceased alive on 12/31, 19.49, and that death occurred at 10:30 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Bobby L. Jones	M.D.	7 Central Ave S.W. Glen Burnie, Md	1/1/50

23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/4/49	Green Mount	Baltimore	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/3/50	Rob. Hedrick Dep.	Milton Cook Dnd	1217 E. Monument St

VS. A15

1949 12-31
1869 7-6
80-5-25

Dr. Allen

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00107

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Town neck
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Town Neck
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Virginia (Middle) [illegible] (Last) Camphar

4. DATE OF DEATH: (Month) Jan (Day) 26 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: May 30, 1882

9. AGE last birthday: 67 yrs. — If under 1 year: Months 7 Days 27 — If under 24 hrs.: Hours [illegible] Min.

10d. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Artest

14. MOTHER'S MAIDEN NAME: Josephine Reid

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Daisy Jennings

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive heart failure

434.1 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
93e (b)

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from 12-15, 1949, to 1-26, 1950, that I last saw the deceased alive on 1-23, 1950, and that death occurred at 7 P m., from the causes and on the date stated above.

SIGNATURE: O. J. Allen — (Degree or title): MD — ADDRESS: 110 Carroll — DATE SIGNED: 1-27-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 29, 1950 — NAME OF CEMETERY OR CREMATORY: Town neck — LOCATION (City, town, or county) (State): Town neck A.A.Co. Md

DATE REC'D BY LOCAL REG.: Jan. 28, 1950 — REGISTRAR'S SIGNATURE: [illegible]

24. FUNERAL DIRECTOR — ADDRESS: J.B. Johnson, Annapolis Md.

RECEIVED
FEB 1 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00108

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY -----
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2038 Druid Hill Ave.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Raymond	----------	Carter	Jan.	28	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months. Days	If under 24 hrs.: Hours Min.
Male	Negro	married	unknown	59 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
unkn.	unkn.	ukn.	U.S.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
unkn.	unkn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS
unkn.	unkn.	Mrs. Hattie Carter 2038 Druid Hill Av

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	3 days
447 Antecedent cause(s)		
97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hypertension	unkn.
	(c) Arteriosclerosis	unkn.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-----	------	Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
-------	-------	------		

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
--------- m.		----------

22. I hereby certify that I attended the deceased from Jan. 20, 1950, to Jan 28, 1950, that I last saw the deceased alive on Jan. 28, 1950, and that death occurred at 2:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.	Crownsville State Hospital	Jan. 29, '50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 1, 1950	Mt. Auburn	Baltimore, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
1/30/50	H.W. Hedrick	Holland Funeral Home	1087 Druid Hill Ave

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06189

Reg. Dist. No. 21-13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clearview Village (Pasadena P.O.)
LENGTH OF STAY (in this place): 5 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Brookfield Road

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Pasadena P.O.
STREET ADDRESS (If rural give location): Clear View Village

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Mary	Jane	Chard	Jan	23	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Single	November 28, 1872	78 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Anne Arundel Co. Maryland
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George Chard
14. MOTHER'S MAIDEN NAME: Nancy Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Raymond Duvall - Pasadena P.O. (Niece)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Acute myocardial failure	30 minutes
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Acute congestive heart failure	3 months
443 93	(c) Hypertension	unknown.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: none.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
			m.		

22. I hereby certify that I attended the deceased from 23 Oct., 1949, to 23 Jan., 1950, that I last saw the deceased alive on 22 Jan., 1950, and that death occurred at 10:45 Am., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Randall M. McLaughlin	Mountain Rd, Pasadena, Md.	Jan. 23, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	1-25-50	Mt. Carmel	Mountain Road, A.A.Co., Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 25 1950	L. J. DeAlba	Thomas W. Singleton	Glen Burnie, Maryland

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JAN 26 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 60110 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Dorchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville, Maryland — LENGTH OF STAY (in this place) 32 years	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cambridge
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	(First) Jane	(Middle)	(Last) Chester	4. DATE OF DEATH	(Month) 1	(Day) 17	(Year) 1950
5. SEX Female	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1889	9. AGE last birthday 60 yrs. yrs.	If under 1 year Months.	Days	If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS Hospital Records				

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cardio-vascular disease with decompensation — Known to us for two. mo.

443 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension

(c) Manic Depressive Psychosis — Known to us since adm.-1917

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/13, 1941, to 1/17/, 1950, that I last saw the deceased alive on January 17, 1950, and that death occurred at 10:55 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Maryland	1/18/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	1/19/50	Cordtown Cemetery	Cordtown near Cambridge	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 18, 1950	E. F. Joyce Local Reg.	Lewis H Brayneman	Cambridge Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00111

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 20 Fleet St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 22 Fleet Street

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Frank.	Dill	Colbert	Jan.	27	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	Colored	Widow	1870	79 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Frank Colbert
14. MOTHER'S MAIDEN NAME: Marie Stewart
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Florence Colbert

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebro-vascular accident

331 x Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
83a (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-23, 1950, to 1-27, 1950, that I last saw the deceased alive on 1-26, 1950, and that death occurred at 12 50 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
T. Allen	M.D.	10 Carroll	1-28-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 30, 1950	Brewer Hill	Annapolis,	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 30, 1950	Wm. D. Church	J. B. Johnson	Annapolis, Md.

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RECEIVED
JAN 31 1950
BUREAU T. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06112

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Days

Hospital, institution, or street address where death occurred: Station Hospital

How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Indiana County: Henry

City or town: New Castle (If outside city or town limits, write RURAL and give nearest town)

Street No.: P O Box # 84 (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: COONEY, BABY BOY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1710 hours January 27, 1950

8. AGE: Years	Months	Days	If less than one day
		2	4 hrs. 45 min.

9. Birthplace: Fort G G Meade, Anne Arundel, Md. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Floyd William Cooney

13. Birthplace: Indiana

MOTHER — 14. Maiden name: Enzie Lavena Ward

15. Birthplace: Indiana

16. Informant: Floyd William Cooney SFC

Address: Fort Geo G Meade, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 30 January 1950 (month) (day) (year)

Cemetery or crematory: Post Cemetery

Location: Fort Geo G Meade, Maryland

18. Funeral director: Theodore Pfeiffer, Major, Chap C

Address: Ft Geo G Meade, Maryland

19. 30 January 1950 (Date rec'd by registrar) James E. Hayes, Capt. MSC, Registrar

2-0-1-27-0-25-4-40-1

MEDICAL CERTIFICATION

20. DATE OF DEATH: 29 January 1950 at 2155 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1710 hrs 27 January 1950 to 2155 29 Jan 1950 and that I last saw him alive on 2155 29 January 1950

Immediate cause of death	DURATION
Fetal atelectasis	
Due to: Prematurity - 28 weeks gestation	
Due to:	
Other conditions: 762.5 159 (Include pregnancy within 3 months of death)	

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank J Shannon Jr

FRANK J. SHANNON JR, Capt. M.C. M. D. or Other

Address: Ft Geo G Meade, Md Date signed: 30 Jan 50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 31 1950
BUREAU U. S.

00113

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Gambrills R F D

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Chesterfield A A Co Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Preston A Creek

3. (b) Social Security Number

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Viola Snowden

dead

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Not known

8. AGE: Years: 61 Months: — Days: — If less than one day: — hrs. — min.

9. Birthplace: Anne Arundel Co Md (Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business

FATHER

12. Name: Charles Creek

13. Birthplace: Maryland

MOTHER

14. Maiden name: Rosie Parker

15. Birthplace: A. A. Co Md

16. Informant: Harrison Creek

Address: Gambrills Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29/50 (month) (day) (year)

Cemetery or crematory: Mt Tabor

Location: Chesterfield, Md

18. Funeral director: J. B. Johnson

Address: Hemapolis

19. Jan. 27 1950 (Date rec'd by registrar) E F Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 26 1950, at 11 45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1949 to Jan 24 1950 and that I last saw him alive on Jan 24 1950

Immediate cause of death: Coronary disease — DURATION: 2 days

Due to: Hypertension — 2 yrs

Due to: Arteriosclerosis — 2 yrs

Other conditions: 420.1 94a

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: O S Mae Nemar M. D. or other

Address: Millersville Md Date signed: 1-26-50

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

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RECEIVED
FEB 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00114

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) nine months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson, Maryland
STREET ADDRESS (If rural, give location) 5 May Avenue

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Thomas (Last) Davis

4. DATE OF DEATH: (Month) k 1/17/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): separated

8. DATE OF BIRTH: 2/2/99

9. AGE last birthday: 50 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) not known (If yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Lung Tuberculosis	known since 1/6/50
002 Antecedent cause(s)		
13b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Mixed Type	known since 5/4/49

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 5/4/49, 19..., to 1/17/50, 19..., that I last saw the deceased alive on 1/17/50, 19... and that death occurred at 8:00A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Crownsville, Md. 1/17/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: Jan. 22nd 1950 — NAME OF CEMETERY OR CREMATORY: Pleasant Rest — LOCATION (City, town, or county) (State): Towson Balto Co Md

DATE REC'D BY LOCAL REG.: Jan 21-50 — REGISTRAR'S SIGNATURE: A. W. Hedrick

24. FUNERAL DIRECTOR: Bafford Mamie H. Wright — ADDRESS: 721 Aisquith St Balto 2-Md

98849

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

60115

Reg. Dist. No. 22

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dorsey
STREET ADDRESS (If rural, give location) Forest Avenue

3. NAME OF DECEASED (Type or Print) (First) George (Middle) Washington (Last) De Pascal

4. DATE OF DEATH (Month) January (Day) 5 (Year) 1950

5. SEX M

6. COLOR OR RACE W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH May 1, 1870

9. AGE last birthday 79 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired

10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.

11. BIRTHPLACE (State or foreign country) Baltimore Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Marion De Pascal

14. MOTHER'S MAIDEN NAME Catherine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) —

16. SOCIAL SECURITY NO. 705-05-3200

17. INFORMANT AND ADDRESS Catherine Leo Pauline De Pascal

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arterio-sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

447x Antecedent cause(s) (b) Hypertension — 5 yrs.

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION ✓

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) ✓

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) ✓ m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1st, 1949, to Jan. 5th, 1950, that I last saw the deceased alive on Jan. 5th, 1950, and that death occurred at 11 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Frank Shipley, M.D. ADDRESS Savage, Md. DATE SIGNED 1/7/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE Jan. 9, 1950

NAME OF CEMETERY OR CREMATORY Meadowridge, Mem. Park

LOCATION (City, town, or county) Dorsey, Maryland (State)

DATE REC'D BY LOCAL REG. Jan 8. 1950

REGISTRAR'S SIGNATURE Clara Haslup

24. FUNERAL DIRECTOR De Witt Donaldson, Laurel Md. ADDRESS

XVX 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

M

I

RECEIVED
JAN 11 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 00116

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: ANNE ARUNDEL — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LINTHICUM HEIGHTS
LENGTH OF STAY (in this place): 16 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LINTHICUM HEIGHTS
STREET ADDRESS (If rural, give location): CHARLES ROAD.

3. NAME OF DECEASED (Type or Print): (First) OLIVER (Middle) WESLEY (Last) DE VENISH

4. DATE OF DEATH: (Month) JAN. (Day) 22 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: Nov. 1, 1869

9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRIEST

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Wesley DeVenish.

14. MOTHER'S MAIDEN NAME: EDITHA BENTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT AND ADDRESS: MRS. O. W. DE VENISH, CHARLES RD. LINTHICUM ~~HEIGHTS~~

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) CONGESTIVE HEART FAILURE	1 mo.
4200 Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 1310	(b) ARTERIOSCLEROTIC HEART DISEASE	10 yrs.
	(c) CHRONIC NEPHRITIS	3 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?:

22. I hereby certify that I attended the deceased from Dec 9, 1949, to Jan. 22 1950, that I last saw the deceased alive on Jan 22, 1950, and that death occurred at 8:28 A m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
C. Milton Linthicum	M.D.	Linthicum Heights Md.	Jan 22, 1950

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Cremation	1-24-50	Loudon Park Cem.	Fred. Ave.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan 23-50	A. W. Hedrick	John O. Mitchell Sons	1900 Eutaw Pl.

VO 294

Evidence for addition of 8 & 9 shown on:

FILM No. G 124 JAN 30 1950

00117

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Millersville

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Ann
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millersville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) David (Middle) (Last) Diggs

4. DATE OF DEATH (Month) 1 (Day) 19 (Year) 1950

5. SEX Male | 6. COLOR OR RACE Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH About 1878 | 9. AGE last birthday approx. 71 yrs. | If under 1 year Months. Days | If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Waterbury Md | 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Diggs | 14. MOTHER'S MAIDEN NAME Sarah Diggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT Annie Diggs

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Multiple Myeloma	3 MO
203 X Antecedent cause(s)		
55e Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arterio-sclerosis

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1948, to Jan 19, 1950, that I last saw the deceased alive on Jan 19, 1950, and that death occurred at 7:40 P m., from the causes and on the date stated above.

SIGNATURE Edward G Merritt (Degree or title) M.D. ADDRESS Gambrills Md DATE SIGNED Jan 19, 1950

23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE 1-22-50 | NAME OF CEMETERY OR CREMATORY John Wesley | LOCATION (City, town, or county) Waterbury Md (State)

DATE REC'D BY LOCAL REG. 1/21/50 | REGISTRAR'S SIGNATURE E. F. Joyce Logue Reg | 24. FUNERAL DIRECTOR William Reese, II-108 Washington St. Annapolis, Md. | ADDRESS

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The [illegible] is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00118

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

1. PLACE OF DEATH: COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville
LENGTH OF STAY (in this place): 9 mos. 28 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore City
STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print): (First) Emory (Middle) (Last) Evans

4. DATE OF DEATH: (Month) 1/6/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): separated

8. DATE OF BIRTH: ~~not known~~ 1887

9. AGE last birthday: 62(?) yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Norfolk, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: not known

14. MOTHER'S MAIDEN NAME: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): not known

16. SOCIAL SECURITY NO.: ********

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Generalized Arteriosclerosis — known since 3/11/49

4500 Antecedent cause(s)

97 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes X No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: none

(CITY OR TOWN): none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour): none m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 3/11/49, 19..., to 1/6/50, 19..., that I last saw the deceased alive on 1/6/50, 19..., and that death occurred at 5:45 A. m., from the causes and on the date stated above.

SIGNATURE: [signature] (Degree or title) M.D. ADDRESS: Crownsville, Maryland DATE SIGNED: 1/7/50

23. BURIAL, CREMATION, REMOVAL (Specify): X — DATE: 1/11.50 — NAME OF CEMETERY OR CREMATORY: Hospital — LOCATION (City, town, or county) (State): Crownsville Md

DATE REC'D BY LOCAL REG. 1/11.50 — REGISTRAR'S SIGNATURE: E. T. Joyce Lane Reg. — 24. FUNERAL DIRECTOR: Supt. Hospital — ADDRESS: Crownsville Md

9589

RECEIVED
JAN 13 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

06119

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Anne Arundel; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis; LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Lusby Bross Rds.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Anne Arundel; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Annapolis,

STREET ADDRESS (If rural give location): Lusby Cross Rd.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) A. (Last) Fischer

4. DATE OF DEATH: (Month) 1- (Day) 4- (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept 26 1873

9. AGE last birthday: 76 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jon M. Schmidtt

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Bernard J. Fischer RFD Annapolis, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 mos +.

151 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 46 (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. None.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2, 1949 to 1/4, 1950, that I last saw the deceased alive on 1/4, 1950 and that death occurred at 10:20 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Marvin K Evans, MD Annapolis, Md 1/5/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 1-9-50

NAME OF CEMETERY OR CREMATORY: Our Lady of the Fields

LOCATION (City, town, or county) (State): Millersville, Maryland

DATE REC'D BY LOCAL REG.: Jan. 7, 1950

REGISTRAR'S SIGNATURE:

24. FUNERAL DIRECTOR ADDRESS: B.L. Hepping and Son

RECEIVED
JAN 10 1950
BUREAU V. S.

00120

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH · COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis — LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
HOSPITAL OR INSTITUTION OR STREET ADDRESS 56 College Creek Terrace	STREET ADDRESS (If rural give location) 56 College Creek Terrace

3. NAME OF DECEASED (Type or Print) (First) Earnest (Middle) N. (Last) Gantt

4. DATE OF DEATH (Month) 1 (Day) 29 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
Male	Negro	Married	12-7-1888	61 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Messenger - U.S. Naval Academy		Annapolis	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Gantt	Martha Gantt Diggs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT
No			James Gantt

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of the Lungs. — 1 year.

163x Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

47d (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☒	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan 15, 1949, to Jan 29, 1950, that I last saw the deceased alive on Jan 29, 1950, and that death occurred at 4:15 A.M. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[signature]	MD	Annapolis, Md.	1/30/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Feb. 2, 1950	Brewer Hill	Annapolis	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 31, 1950	[signature]	William Reese, II - 104 Washington St. Annapolis, Md	

224-96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1950
BUREAU V. S.

Evidence for change of age, shown on

FILM No. G 123 JAN 10 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

00121

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel Co. — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (In this place): 70 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 4 Water St (Vansand)

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
STREET ADDRESS (If rural give location): 4 Water St (Vansand)

3. NAME OF DECEASED (Type or Print): (First) Georgiana (Middle) (Last) Gilchrist

4. DATE OF DEATH: (Month) 1 (Day) 2 (Year) 1950

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12/ 15/ 1888

9. AGE last birthday: 61 ~~62~~ yrs. — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Annapolis, Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Issac Whipple

14. MOTHER'S MAIDEN NAME: Adline Howard

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Paul Gilchrist

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Colon

153 X

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

46 e

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY | (CITY OR TOWN) Annapolis | (COUNTY) Aa | (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-6 1949 to 1-2 1950, that I last saw the deceased alive on 12-29 1949, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE: G. F. Allen — (Degree or title) MD — ADDRESS 10 Conduit St — DATE SIGNED 1-3-50

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE THEREOF: 1/ 4/ 1950 | NAME OF CEMETERY OR CREMATORY: St Marys | LOCATION (City, town, or county) (State): West St. Extended- Annapolis

DATE REC'D BY LOCAL REG.: Jan 4, 1950 | REGISTRAR'S SIGNATURE: [illegible] | **24. FUNERAL DIRECTOR** ADDRESS: Mrs. Charles E. Hicks & Son — 45 Northwest St.

520-86

RECEIVED
JAN 5 1950
BUREAU V. S.

00122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH- COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 5 yrs. 6 mos.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): not known

3. NAME OF DECEASED (Type or Print)	(First) Oscar	(Middle)	(Last) Hall	4. DATE OF DEATH (Month) 1/28/50 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 8/25/98	9. AGE last birthday: 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): musician	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): North Carolina	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Robert Hall		14. MOTHER'S MAIDEN NAME: Delia Lewis		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	known since
331x Antecedent cause(s)		1/22/50
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Schizophrenia, Paranoid Type	known since
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		7/10/44

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none	(CITY OR TOWN) (COUNTY) (STATE): none
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 7/10/44, 19....., to 1/28/50, 19....., that I last saw the deceased alive on 1/28/50, 19....., and that death occurred at 6:05 P.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Margaretten	M.D.	Crownsville, Md.	1/28/50

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 2/1.50	NAME OF CEMETERY ~~OR CREMATORY~~: Hospital	LOCATION (City, town, or county) (State): Crownsville Md
DATE REC'D BY LOCAL REG.: 2/1.50	REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg.	24. FUNERAL DIRECTOR: Supt Hospital	ADDRESS: Crownsville Md

V28-90

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A151

RECEIVED
FEB 3 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00123

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co. General Hospt.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A.A.Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural, give location) 104 Conduit St.

3. NAME OF DECEASED (Type or Print): (First) DANIEL (Middle) (Last) HUETHER
4. DATE OF DEATH: (Month) 1 (Day) 6 (Year) 1950

5. SEX: M. 6. COLOR OR RACE: White 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) 8. DATE OF BIRTH: 9/25/1889 9. AGE last birthday: 60 yrs. If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker U.S.N.A. Ret. 10b. KIND OF BUSINESS OR INDUSTRY: Baker 11. BIRTHPLACE (State or foreign country): Baltimore Md. 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Louis Huether 14. MOTHER'S MAIDEN NAME: Katherine Berkheimer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocarditis Chr. & Myocardial Insufficiency — 1 year.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chr. Interstitial Nephritis — 2 years

(c) Hypertension — 2 years

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Decubitis Malleoli — 4 years

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1945, to Jan 6, 1950, that I last saw the deceased alive on Jan 6, 1950, and that death occurred at 1 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George E. Basil M.D. Annapolis Md 1-8-50

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 1/9/50 NAME OF CEMETERY OR CREMATORY Baltimore Cemetery LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REG. Jan. 9, 1950 REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

496-96

JAN 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00124

CERTIFICATE OF DEATH

Reg. Dist. No. 28

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 5 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY BaltimoreCit
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
STREET ADDRESS (If rural, give location) 2206 Penna. Aven.

3. NAME OF DECEASED (Type or Print) (First) Mabel (Middle) (Last) Jackson

4. DATE OF DEATH (Month) 1/23/50 (Day) (Year) 19

5. SEX female

6. COLOR OR RACE colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) not known

8. DATE OF BIRTH not known

9. AGE last birthday 52(?) yrs. If under 1 year Months / Days; If under 24 hrs. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) not known

10b. KIND OF BUSINESS OR INDUSTRY none

11. BIRTHPLACE (State or foreign country) not known

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME not known

14. MOTHER'S MAIDEN NAME not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. [redacted]

17. INFORMANT AND ADDRESS Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) General Paresis — Interval between onset and death: known since 8/19/49

Antecedent cause(s)

025

30b

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION none

19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY? Yes ☐ No ☐ no

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) none (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) none (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 8/19/49, 19..., to 1/23/50, 19..., that I last saw the deceased alive on 1/23/50, 19..., and that death occurred at 9:40 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Jacob Thrasher M.D. ADDRESS Crownsville, Maryland DATE SIGNED 1/24/50

23. BURIAL, CREMATION REMOVAL (Specify) ✓ DATE 1-26-50 NAME OF CEMETERY OR CREMATORY Fitzgerald Cem. LOCATION (City, town, or county) Blackstone (State) Va

DATE RECD BY LOCAL REG. 1/24-50 REGISTRAR'S SIGNATURE E. F. Joyce Local Reg

24. FUNERAL DIRECTOR W. J. Scott - Blackstone Va ADDRESS

VS. A15

RECEIVED
JAN 26 1950
BUREAU V. S.

Evidence for addition in 18 shown on: FILM No. G 1 2 4 FEB 15 1950

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00125

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Magoty Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Robert S. Jenkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

B.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 26, 1904

8. AGE: Years	Months	Days	If less than one day
45			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Cephas Jenkins
13. Birthplace: Md

MOTHER
14. Maiden name: Mamine Carter
15. Birthplace: Md

16. Informant: Melvina Brown
Address: Magoty Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/5/50 (month) (day) (year)
Cemetery or crematory: Magoty Cemetery
Location: Annie Arundel Co., Md.
18. Funeral director: J. L. Brown & Son
Address: 108 W. Montgmonery Street

19. 1/4 (Date rec'd by registrar) 19 50 H. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 2, 1950 19 at 9-45 A

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from 12/27 19 49, to Jan. 2 19 50
and that I last saw h. IM alive on Dec. 31 19 49

Immediate cause of death	DURATION
Pneumonia, Broncho (underlying cause -2/15/50-ams)	1 week
Due to: Degenerative Cardio-Vascular Renal	1 year
Due to:	
Other conditions: 491 932 (Include pregnancy within 3 months of death)	

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Brady Smith M.D.
M. D. or other
Address: Riviera Beach Md. Date signed: 1/2/50

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00126

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS U.S. General

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eastport
STREET ADDRESS (If rural, give location) 422 State St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) C. (Last) Jones

4. DATE OF DEATH: (Month) 1 (Day) 15 (Year) 19 50

5. SEX: Male

6. COLOR OR RACE: W.

7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: 1-26-1875

9. AGE last birthday: 74 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Molder

10b. KIND OF BUSINESS OR INDUSTRY: Navy yard Washington D.C.

11. BIRTHPLACE (State or foreign country): Baltimore Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Rodger C. Jones Eastport Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Jan 7-50

420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 93d (b) Myocarditis Chr. & Myocardial — unknown

(c) Insufficiency

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — unknown

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 7, 1950, to Jan 15, 1950, that I last saw the deceased alive on Jan 15, 1950, and that death occurred at 10 p m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George C. Basil M.D. Annapolis Md 1-17-50

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

1-18-49 | Cedar Bluff | Annapolis Md

DATE REC'D BY LOCAL REG. Jan. 18, 1950 | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS

John M. Taylor Son Annapolis Md.

496-4V

RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00127

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 29

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville; LENGTH OF STAY (in this place) 4 mos. 11days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Queen Anne
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chestertown
STREET ADDRESS (If rural give location) R.F.D. 1

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Ralph (Last) Lee

4. DATE OF DEATH: (Month) 1/19/50 (Day) (Year) 19

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: ~~not known~~ 1921

9. AGE last birthday: 28 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Eastern Shore, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: William Elliott

14. MOTHER'S MAIDEN NAME: MARY V. not known LEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service) LL

16. SOCIAL SECURITY No.: not known

17. INFORMANT: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Compression of Medulla Oblongata	Sudden Death
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture & Dislocation of Cervical Vertebra I and II	known since Nov. 23, 1949
	(c) Schizophrenia, Paranoid Type known since 9/8/49	

300.7
845
9551

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION: none

20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: hospital

(CITY OR TOWN) (COUNTY) (STATE): Crownsville, Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): 11/21/49 m.

INJURY OCCURRED While at work [ ] Not while at work [ ]

HOW DID INJURY OCCUR? During Electro-Shock Treatment

22. *I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [ ] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [ ], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Claffy M.D. Deputy Medical Examiner, Annapolis Md. 1-19-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial; DATE THEREOF: Jan 22, 1950; NAME OF CEMETERY OR CREMATORY: RICH NECK HALL Cem.; LOCATION (City, town, or county) (State): QUEEN ANNE CO Md.

DATE REC'D BY LOCAL REG. 1/19.50; REGISTRAR'S SIGNATURE: E. Hoyce Lowe Reg

24. FUNERAL DIRECTOR: J. Willis Wells; ADDRESS: Chestertown, md.

VS. A15A

000VV

Mr. Russell
Fletcher.
Mr. Joyce.

Chased on Rt.

Rt. ook.

RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

60128

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Laurel. Rural
LENGTH OF STAY (in this place) 1 yr 2 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS District Training School

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE D.C. — COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural, give location) 5347 C St. S.E. ✓

3. NAME OF DECEASED (Type or Print): (First) Terry (Middle) (Last) Lewis

4. DATE OF DEATH: (Month) Jan (Day) 31 (Year) 1950

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S

8. DATE OF BIRTH: 7-17-46

9. AGE last birthday: 3 yrs. If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Curtis Lewis

14. MOTHER'S MAIDEN NAME: Irene —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT AND ADDRESS: Dr. Huff by History of D.T.S.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Hydrocephalus (congenital) — Interval Between Onset and Death: Birth

7520 Antecedent cause(s)

1570 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) —

(c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-5-48, to 1-31-50, that I last saw the deceased alive on 1-31-50, and that death occurred at 8:25 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Richard D Huff M.D. ADDRESS: Laurel. Md Rural DATE SIGNED: 1-31-50

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE: Feb 2-50 | NAME OF CEMETERY OR CREMATORY: West Fr School | LOCATION (City, town, or county) (State): Laurel RFD Md

DATE REC'D BY LOCAL REG.: Feb 1-50 | REGISTRAR'S SIGNATURE: Clara Haslup

24. FUNERAL DIRECTOR: Raymond Jones ADDRESS: Laurel Md

RECEIVED
MAR 1 1950
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

00129

Reg. Dist. No. 25

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ~~Maryland~~ Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Brooklyn
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Moreland Convalescent Home

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgewood
STREET ADDRESS (If rural, give location) 4404 Highview Ave.

3. NAME OF DECEASED (Type or Print): (First) WILLIAM (Middle) F. (Last) MARGRAF

4. DATE OF DEATH: (Month) January (Day) 28, (Year) 1950

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Jan. 15, 1909

9. AGE last birthday: 41 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Journeyman Pressman

10b. KIND OF BUSINESS OR INDUSTRY: Newspaper Prntg

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Garfield Margraf

14. MOTHER'S MAIDEN NAME: -

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212-07-4048

17. INFORMANT: Mrs. Margaret Margraf 4404 Highview Av

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Paraldehyde poisoning — Interval between onset and death:

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

874.0
179x

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
(CITY OR TOWN) (COUNTY) (STATE): 4404 Highview, ARBUTUS, MD.

TIME OF INJURY (Month) (Day) (Year) (Hour): 1-27-50 p.m.
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Ingestion of paraldehyde

22. *I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☒, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Earl L Royer M.D. 700 Fleet Street 1-28-50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: 2/1/50
NAME OF CEMETERY OR CREMATORY: Loudon Park Cem.
LOCATION (City, town, or county) (State): Balto., Md.

DATE REC'D BY LOCAL REG. 1-30-50
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR: WM. J. TICKNER & SONS ADDRESS: Balto., Md.

39214

VS-A15A

M

00130

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Balto City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (in this place) 15 days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore City
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural, give location) 501 N. Parrish Street ✓

3. NAME OF DECEASED (Type or Print) (First) Samuel	(Middle) ------	(Last) Matthews	4. DATE OF DEATH (Month) 1.	(Day) 12th	(Year) 1950
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 5/16/1942	9. AGE last birthday 7 yrs.	If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----------	10b. KIND OF BUSINESS OR INDUSTRY ----------	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Samuel Matthews		14. MOTHER'S MAIDEN NAME Gertrude Dixon			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ------- (If year, give war or dates of service) -----	16. SOCIAL SECURITY NO. ----------	17. INFORMANT Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Uremia	known since 1/1/50
Antecedent cause(s)		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Hemorrhagic Nephritis	
	(c) Idiocy with Congenital Spastic Diplegia	Known to us since admission

351

87e

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION ----------	19b. MAJOR FINDINGS OF OPERATION ----------	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify) ---------	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -------	(CITY OR TOWN) (COUNTY) (STATE) ----------
TIME OF INJURY (Month) (Day) (Year) (Hour) ---------- m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? ----------

22. I hereby certify that I attended the deceased from 12/28, 1949, to 1/12, 1950, that I last saw the deceased alive on 1/12, 1950 and that death occurred at 7:45 p.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville State Hospital	1-13-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 1/16/50	NAME OF CEMETERY OR CREMATORY Mt Calvary	LOCATION (City, town, or county) (State) A.A. County Md
DATE REC'D BY LOCAL REG. 1/16/50	REGISTRAR'S SIGNATURE A.W. Hedrick DM	24. FUNERAL DIRECTOR Charles G Cooper	ADDRESS 512 Canvelton Av. Balto Md

XVX99

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00131

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A. A. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold
STREET ADDRESS (If rural give location) Arnold P.O.

3. NAME OF DECEASED (Type or Print) (First) Everett (Middle) Doerr (Last) Moreton
4. DATE OF DEATH (Month) Jan (Day) 18 (Year) 1950
5. SEX Male
6. COLOR OR RACE W.
7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH 7-14-1889
9. AGE last birthday 60 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY Engineer
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? N. A.
13. FATHER'S NAME Eben Moreton
14. MOTHER'S MAIDEN NAME Susan Doerr
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Edith G Moreton Arnold Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary thrombosis	1/4 hrs.
420.1 93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) arteriosclerotic cardiovascular disease	5-10 yrs.
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1947, to Jan 18, 1950, that I last saw the deceased alive on Jan 16, 1950, and that death occurred at 4 30 a m., from the causes and on the date stated above.

SIGNATURE S. Bernuch (Degree or title) M.D. ADDRESS Annapolis Md DATE SIGNED 1/18/50

23. BURIAL, ~~CREMATION~~ ~~REMOVAL~~ (Specify)
DATE THEREOF 1-21-1950
NAME OF CEMETERY OR CREMATORY Loundon Park
LOCATION (City, town, or county) (State) Baltimore Md.

DATE REC'D BY LOCAL REG. Jan. 19, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR John M. Taylor Son ADDRESS Annapolis Md.

356-94

RECEIVED
JAN 21 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00132

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis Md — LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md — COUNTY A A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberstone
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Dorsey (Last) Murray

4. DATE OF DEATH: (Month) Jan (Day) 28 (Year) 1950

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widower

8. DATE OF BIRTH: Nov 2 1862

9. AGE last birthday: 87 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Law

10b. KIND OF BUSINESS OR INDUSTRY: Law

11. BIRTHPLACE (State or foreign country): Gardiner Maine

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Robert Murray

14. MOTHER'S MAIDEN NAME: Adelaide Atwood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miss Anne C Murray

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) arteriosclerotic cardiovascular disease — over 20 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) 422.1 93d

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 19 48, to Jan 28, 1950, that I last saw the deceased alive on Jan 28, 1950, and that death occurred at 9:15 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

J. Boorsch. M.D — Annapolis Md — 1/28/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF 1/30/50 | NAME OF CEMETERY OR CREMATORY: Christ Church | LOCATION (City, town, or county) (State): Owensville Md.

DATE REC'D BY LOCAL REG.: Jan. 30, 1950 | REGISTRAR'S SIGNATURE: [signature] | 24. FUNERAL DIRECTOR: T A Hardesty & Son | ADDRESS: Glenville Md

V26 -93

RECEIVED
JAN 31 1950
BUREAU V. S.

mw

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

T

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

06133

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel County MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bowie
STREET ADDRESS (If rural, give location) Bowie Race Track Road.

3. NAME OF DECEASED (Type or Print) (First) FREDERICK (Middle) J (Last) NIXON
4. DATE OF DEATH (Month) 1-4- (Day) (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Divorced
8. DATE OF BIRTH Dec. 25-1893
9. AGE last birthday 56 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer & Truckdriver
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Laconia New Hampshire
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?
14. MOTHER'S MAIDEN NAME ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-07-7376
17. INFORMANT John F. Nixon - 508 Rappolla St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Asphyxia

816.5 Antecedent cause(s) due to
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Aspiration of blood

170c due to
(c) Severe lacerations of throat

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Public (road)
(CITY OR TOWN) (COUNTY) (STATE) Routes 50 and 301 near Bowie, Waterloo, Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) January 4, '50 pm
INJURY OCCURRED While at work ☐ Not while at work ☒
HOW DID INJURY OCCUR? Two-truck collision

22. *I certify that I took charge of the remains described above, held an Autopsy* ☒, *Inspection* ☐, *Inquiry* ☐ *thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said ~~deceased died~~ on the day stated above, and death in my opinion resulted from: natural causes* ☐, *accident* ☒, *suicide* ☐, *homicide* ☐, *undetermined* ☐.

SIGNATURE (Degree or title) Russell S Fisher MD
ADDRESS 700 Fleet Street
DATE SIGNED 1-4-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 1-9-50
NAME OF CEMETERY OR CREMATORY Balto National
LOCATION (City, town, or county) (State) Balto Md

DATE REC'D BY LOCAL REG. 1/6/50
REGISTRAR'S SIGNATURE A. W. Hedrick LDM
24. FUNERAL DIRECTOR Leonard J Fluck - 5305 Harford Rd.
ADDRESS

988-50

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00134

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis | LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 83 Washington St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 83 Washington St

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Edward (Last) Parker

4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 1950

5. SEX: Male | 6. COLOR OR RACE: Negro | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): widowed | 8. DATE OF BIRTH: 12-28-1863 | 9. AGE last birthday: 86 yrs. | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lumber | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country): Annapolis Md. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Parker | 14. MOTHER'S MAIDEN NAME: Leatha Baker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT: Joyce Parker

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myasthenia Gravis

744.0 Antecedent cause(s)

156b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-25 1949, to 1-18 1950, that I last saw the deceased alive on 1-18 1950, and that death occurred at 7:35 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H. J. Allen M D 10 Carroll 1-21-50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE 1-22-1950 | NAME OF CEMETERY OR CREMATORY Brewer Hill | LOCATION (City, town, or county) (State) West St Annapolis

DATE REC'D BY LOCAL REG. Jan. 22, 1950 | REGISTRAR'S SIGNATURE [signature] | 24. FUNERAL DIRECTOR William Reese II | ADDRESS 108 Washington St Annapolis, Md. 348-W

VS. A15

JAN 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00135

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH · COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis — LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Anne Arundel — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: ODETON
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ELAINE	S	QUEEN	1	24	19 50

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	If under 1 year Months	Days	If under 24 hrs. Hours	Min.
F	C	SINGLE	10-5-49		3	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
CHILD	—	MARYLAND	

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME: DOROTHY ROLLINS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) SHOCK - SEVERE HEMORRHAGE	1 DAY
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) ACUTE BRONCHITIS WITH VOMITING	7 DAYS
	(c)	

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1060

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1-24, 1950, to 1-24, 1950, that I last saw the deceased alive on 1-24, 1950, and that death occurred at 11 45 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Philip Proctor		212 Prince George St. Annapolis	1-25-50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	Jan. 29/50	Forks	Patuxent	Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Jan. 27, 1950	M. D. Mouch	J. B. Johnson	

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RECEIVED
JAN 31 1950
BUREAU V. S.

00136

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE 1512 W.Fairmont Ave COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville — LENGTH OF STAY (In this place) 2/18/46	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital	STREET ADDRESS (If rural give location) 1512 W.Fairmont Ave.

3. NAME OF DECEASED (Type or Print) (First) GEORGE (Middle) (Last) REDDICK		4. DATE OF DEATH (Month) (Day) (Year) January 21, 1950 19	
5. SEX male	6. COLOR OR RACE colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 1918
9. AGE last birthday 31 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME Mrs. Elsie Skinner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Hospital records	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Respiratory Failure	sudden death
300.7 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Following electro-shock treatment	
84b	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Schizophrenia - 4 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☑ No ☐
21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Gaffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 1/21/50

23. BURIAL, CREMATION ~~REMOVAL~~ (Specify)	DATE THEREOF 2-2-50	NAME OF CEMETERY ~~OR CREMATORY~~ Hospital	LOCATION (City, town, or county) Crownsville Md (State)
DATE REC'D BY LOCAL REG. 2/2-50	REGISTRAR'S SIGNATURE E.F. Joyce Local Reg.	24. FUNERAL DIRECTOR Supt Hospital Crownsville Md	ADDRESS

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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RECEIVED
FEB 6 1950
BUREAU V. S.

00137

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Earl Port
LENGTH OF STAY (In this place) 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS 225 Severn Ave

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE NEW JERSEY COUNTY Cumberland
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN VINELAND
STREET ADDRESS (If rural, give location) SOUTHEAST AVE

3. NAME OF DECEASED (Type or Print) (First) EDMUND (Middle) HENRY (Last) REEMAN
4. DATE OF DEATH (Month) Jany. (Day) 9. (Year) 1950
5. SEX MALE
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH JULY 5, 1881
9. AGE last birthday 68 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming
10b. KIND OF BUSINESS OR INDUSTRY Poultry Farm
11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME George Reeman
14. MOTHER'S MAIDEN NAME Jane Whiting
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Winifred A. Reeman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion	Sudden
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary sclerosis	unknown
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE John M. Claffy, M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis, Md DATE SIGNED 1/9/50

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 1-12-1950 NAME OF CEMETERY OR CREMATORY Siloam Cemt. LOCATION (City, town, or county) Vineland (State) N. J.

DATE REC'D BY LOCAL REG. Jan. 9, 1950 REGISTRAR'S SIGNATURE [signature] 24. FUNERAL DIRECTOR John M. Taylor Sons ADDRESS Annapolis Md.

000VV

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

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JAN 11 1950
BUREAU W. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00138

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Annapolis
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: ANNE ARUNDEL GENERAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Glaisville Md.
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) THOMAS (Middle) PORTER (Last) ROGERS

4. DATE OF DEATH: (Month) JAN. (Day) 7 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: DEC. 19, 1889

9. AGE last birthday: 60 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: WILLIAM T. ROGERS

14. MOTHER'S MAIDEN NAME: ALBERTA ATWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): no

16. SOCIAL SECURITY No.: no

17. INFORMANT AND ADDRESS: PAUL ROGERS

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a): Acute myocarditis — INTERVAL BETWEEN ONSET AND DEATH

241 × Antecedent cause(s)

92a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b): Bronchial asthma

(c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 10, 1949, to Jan 7, 1950, that I last saw the deceased alive on Jan 6, 1950, and that death occurred at 11:15 a. m., from the causes and on the date stated above.

SIGNATURE: Emily H. Wilson (Degree or title): M.D. ADDRESS: Lothian, Md. DATE SIGNED: 1-9-50

23. BURIAL, CREMATION, REMOVAL (Specify): DATE: JAN. 9-1950 — NAME OF CEMETERY OR CREMATORY: QUAKER CEM — LOCATION (City, town, or county) (State): Glaisville Md

DATE REC'D BY LOCAL REG.: Jan. 9, 1950 — REGISTRAR'S SIGNATURE: [signature]

24. FUNERAL DIRECTOR ADDRESS: D.C. Hardesty & Son Glaisville Md.

308-VI

RECEIVED
JAN 10 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00139

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Anne Arundel General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural
STREET ADDRESS (If rural give location) RFD Annapolis

3. NAME OF DECEASED (Type or Print) (First) William (Middle) Hines (Last) Rogers
4. DATE OF DEATH (Month) January (Day) 31 (Year) 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH Nov. 7, 1899
9. AGE last birthday 50 yrs. If under 1 year Months 2 Days 24 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber
10b. KIND OF BUSINESS OR INDUSTRY Barbering
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert L. Rogers
14. MOTHER'S MAIDEN NAME Roxie Hines Scarborough

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 3 yrs
16. SOCIAL SECURITY NO. 214-05-0855
17. INFORMANT Mrs. Myrtle Alton Rogers (Wife)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Trauma of Heart c̄ bleeding in right auricle	52 hours
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Fracture of pelvis –	"
	(c) Fracture 6th + 7th ribs left side	"

816.5
170c

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes [X] No [ ]

21. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH.
PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.) U.S. Route 301 (CITY OR TOWN) Millersville (COUNTY) A.A. (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) July 29, 1950 6:00 p.m.
INJURY OCCURRED While at work [ ] Not while at work [X]
HOW DID INJURY OCCUR? Auto-Collision at intersection at Anderson's Corners

22. *I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [ ] thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes [ ], accident [X], suicide [ ], homicide [ ], undetermined [ ].*

SIGNATURE John M. Caffey M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md DATE SIGNED 2-3-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 2-3-50
NAME OF CEMETERY OR CREMATORY Arlington National Cemet.
LOCATION (City, town, or county) Arlington, Va. (State)

DATE REC'D BY LOCAL REG. Feb. 3, 1950
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ben L. Hopping and Son ADDRESS Annapolis, Md.

700-89

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
FEB 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00140

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH: COUNTY Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crownsville
LENGTH OF STAY (in this place) 3½ yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Crownsville State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Manokin
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Corrine (Middle) (Last) Shreeves
4. DATE OF DEATH: (Month) 1-26-50 (Day) (Year) 19

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Separated
8. DATE OF BIRTH: 1921
9. AGE last birthday: 28 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work
10b. KIND OF BUSINESS OR INDUSTRY: - - - -
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - - - - -
(If year, give war or dates of service): - - - - -
16. SOCIAL SECURITY NO.: - - - - - - - - -
17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Catatonic Stupor — Interval Between Onset and Death: 8 days

300.2 Antecedent cause(s) (b) Schizophrenia-CAtatonic — Known to us since adm. 6/5/46

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: - - - - -
19b. MAJOR FINDINGS OF OPERATION: - - - - - - - -

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FEB 3 1930
BUREAU V. S.

00141

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH · COUNTY: Anne Arundel MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Balt. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place):	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 1005 Linden Avenue

3. NAME OF DECEASED (Type or Print) (First) Blanch (Middle) (Last) Skinner			4. DATE OF DEATH (Month) 1/20/50 (Day) (Year) 19	
5. SEX: female	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow	8. DATE OF BIRTH: ~~not known~~ about 1883	9. AGE last birthday: 66 yrs. If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): not known	12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: not known		14. MOTHER'S MAIDEN NAME: not known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT: Hospital Records		

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	known since 1/17/50
331 × Antecedent cause(s)	(b)	
83a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Cerebral Arteriosclerosis	known since 3/12/45

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes X ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): none	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): none	(CITY OR TOWN) none (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 3/12/45, 19....., to 1/20/50, 19....., that I last saw the deceased alive on 1/20/50, 19....., and that death occurred at 4:20 A. m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern	M.D.	Crownsville, Md.	1/21/50

23. BURIAL, CREMATION REMOVAL (Specify)	DATE: 2/3-50	NAME OF CEMETERY OR CREMATORY: Hospital	LOCATION (City, town, or county) (State): Crownsville Md
DATE REC'D BY LOCAL REG.: 2/3/50	REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg	24. FUNERAL DIRECTOR: Supt. Hospital	ADDRESS: Crownsville Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 6 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00142

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH — COUNTY: Anne Arundel — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury — LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Waterbury

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: A. A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Waterbury
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Smith

4. DATE OF DEATH: (Month) 1 (Day) 11 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 1893

9. AGE last birthday: 57 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Waterbury, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Carrie Smith

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Heart Failure	
420.1 **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Coronary Heart Disease	1 wk
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or conditfon causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): No

PLACE (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/4/50, 19....., to 1/11/50, 19....., that I last saw the deceased alive on 1/11/50, 19....., and that death occurred at 2:A.M. m., from the causes and on the date stated above.

SIGNATURE: Theodore H. Johnson — (Degree or title) M.D. — ADDRESS: 40 Northwest Street Annapolis, Md — DATE SIGNED: 1/12/50

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 1-14-1950 — NAME OF CEMETERY OR CREMATORY: Johns Wesley — LOCATION (City, town, or county) (State): Waterbury, Md.

DATE REC'D BY LOCAL REG.: Jan. 14, 1950 — REGISTRAR'S SIGNATURE: E. F. Joyce Local Reg

24. FUNERAL DIRECTOR: William Reese — ADDRESS: 108 Washington St Annapolis, Md.

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RECEIVED
JAN 19 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00143

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY Anne Arundel. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Raynor Heights. LENGTH OF STAY (In this place) 5 years.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hammonds Ferry Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Same.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) William (Middle) J. (Last) Snyder.

4. DATE OF DEATH (Month) Jan. (Day) 9 (Year) 1950

5. SEX Male.
6. COLOR OR RACE White.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Separated
8. DATE OF BIRTH 12/15/89
9. AGE last birthday 60 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assistant Sup. Gas & Electric Co.
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Baltimore, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Georges Snyder
14. MOTHER'S MAIDEN NAME ✓ Kate Litchenberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ✓
17. INFORMANT Mr. George V. Snyder.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary Occlusion.	sudden.
593 X Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 94a	(b) Renal disease	?
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
INJURY OCCURRED While at work ☐ Not while at work ☐ —
HOW DID INJURY OCCUR? —

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE Gustaf H. Faeber M.D. (Degree or title) assistant Deputy Med. Exam. ADDRESS Glen Burnie, Md. DATE SIGNED 1/9/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF 1-12-50
NAME OF CEMETERY OR CREMATORY Western
LOCATION (City, town, or county) Baltimore (State) Md.

DATE REC'D BY LOCAL REG. Jan 10-50
REGISTRAR'S SIGNATURE A. H. Hedrich
24. FUNERAL DIRECTOR George L. Schwab ADDRESS 2101 Frederick Ave. Baltimore 23, Md.

316-59

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15A

00144

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY A.A. Co. MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
LENGTH OF STAY (in this place) 10 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS A.A. Co. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A.A. Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pines-on-Severn
STREET ADDRESS (If rural give location) (above)

3. NAME OF DECEASED (Type or Print) (First) Lester (Middle) Donn (Last) Stevens
4. DATE OF DEATH (Month) (Day) (Year) January 4 1950

5. SEX Male
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH July 23/1902
9. AGE last birthday 47 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk
10b. KIND OF BUSINESS OR INDUSTRY P.O.
11. BIRTHPLACE (State or foreign country) Balto. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Lester L. Stevens
14. MOTHER'S MAIDEN NAME Mabel Donn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 217-16-3160
17. INFORMANT L.L. Stevens-(Father) Balto.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Gastric hemorrhage	27 hrs.
541.0 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Duodenal or peptic ulcer	?
117a	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3, 1950, to 1/4, 1950, that I last saw the deceased alive on 1/4, 1950, and that death occurred at 1.45 P.m., from the causes and on the date stated above.

SIGNATURE Maurice F Klawans, Md (Degree or title) ADDRESS Annapolis, Md DATE SIGNED 1/4/50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE THEREOF Jan 7-50
NAME OF CEMETERY OR CREMATORY Druid Ridge
LOCATION (City, town, or county) (State) Pikesville

DATE REC'D BY LOCAL REG. 1/6/50
REGISTRAR'S SIGNATURE D.W. Hedrick
24. FUNERAL DIRECTOR Stewart Morrow Co. ADDRESS Balto.

26695

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

00145

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Anne Arundel; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Severn; LENGTH OF STAY (In this place) ?; HOSPITAL OR INSTITUTION OR STREET ADDRESS Watts Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY C; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 6; STREET ADDRESS (If rural, give location) 4623 Bonleys Lane

3. NAME OF DECEASED (Type or Print): (First) ARTHUR- (Middle) ZDZISLAW- (Last) SZYMCZEWSKI.

4. DATE OF DEATH: (Month) JANY (Day) 4 (Year) 1950

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10/27/87

9. AGE last birthday: 62 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Austria

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. ?

17. INFORMANT: Stephamia Szymczewski Same Address

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) SUICIDE

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CARBON-MONOXIDE GAS

(c)

973.3
1630

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, office building) OF INJURY Watts Av. (CITY OR TOWN) Severn (COUNTY) A.A. (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour) JAN. 4, 1950 11.30 a.m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐.*

SIGNATURE John M. Caffy M.D. (Degree or title) Deputy Medical Examiner ADDRESS Annapolis Md. DATE SIGNED 1/4/50

24. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF 1/6/1950; NAME OF CEMETERY OR CREMATORY Holy Redeemer; LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR Lilly & Zeiler Inc. ADDRESS 403 S. Wolfe St. Balto.

XVX94

MARYLAND STATE DEPARTMENT OF HEALTH

00146

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY A. A. MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS 3 Dean St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY A A; CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Annapolis; STREET ADDRESS (If rural give location) 3 Dean St.

3. NAME OF DECEASED (Type or Print): (First) Clarence (Middle) (Last) Thomas

4. DATE OF DEATH: (Month) 1 (Day) 20 (Year) 1950

5. SEX: Male

6. COLOR OR RACE: W

7. SINGLE, ~~MARRIED~~, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)

8. DATE OF BIRTH: Aug 9th 1893

9. AGE last birthday: 56 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee of State of Md.

10b. KIND OF BUSINESS OR INDUSTRY: Watchman

11. BIRTHPLACE (State or foreign country): Annapolis Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Thomas

14. MOTHER'S MAIDEN NAME: Laura V. Clow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs Clara Carroll Annapolis Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cancer of Larynx & Throat — 6 Mos.

161 45f Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — Unknown

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1949, to Jan 20, 1950, that I last saw the deceased alive on Jan 20, 1950, and that death occurred at 8.17 m., from the causes and on the date stated above.

SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED

George C. Bovil | M D. | Annapolis Md | 1-21-50

23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF 1-22-1950 | NAME OF CEMETERY OR CREMATORY Cedar Bluff | LOCATION (City, town, or county) Annapolis (State) Md

DATE REC'D BY LOCAL REG. Jan 22, 1950 | REGISTRAR'S SIGNATURE | FUNERAL DIRECTOR John M. Taylor Son | ADDRESS Annapolis Md.

602-97

RECEIVED
JAN. 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00147

CERTIFICATE OF DEATH

Reg. Dist. No. 27

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY ANNE ARUNDEL MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft Geo G. Meade
LENGTH OF STAY (in this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ft GEO. G. MEADE
STREET ADDRESS NC-107 (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) LOUISE (Middle) PHILIPPINE (Last) THOMPSON

4. DATE OF DEATH (Month) JAN (Day) 15 (Year) 1950

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) DIVORCED
8. DATE OF BIRTH 22 JAN 1883
9. AGE last birthday 66 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
11. BIRTHPLACE (State or foreign country) HOUSTON, TEXAS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CHRIS KRUPP
14. MOTHER'S MAIDEN NAME ALVINA CHRISTOPH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If year, give war or dates of service)
16. SOCIAL SECURITY No. —
17. INFORMANT AND ADDRESS CWO Carlton Thompson, Ft Geo. G. Meade, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Pancreas with Extensive Spread

157X

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

46g (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 16 DEC 1949
19b. MAJOR FINDINGS OF OPERATION Carcinoma of Pancreas
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-14, 1950, to 1-15, 1950, that I last saw the deceased alive on 1-14-50, 19..... and that death occurred at 0642 m., from the causes and on the date stated above.

SIGNATURE J S Mitchener Jr. (Degree or title) MD ADDRESS Ft. Meade DATE SIGNED 1-15-50

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 17 January 50
NAME OF CEMETERY OR CREMATORY Laurel Cemetery
LOCATION (City, town, or county) (State) Laurel, Maryland

DATE REC'D BY LOCAL REG. 17 Jan 50
REGISTRAR'S SIGNATURE JAMES E. HAYES, Capt. MSC James E Hayes
24. FUNERAL DIRECTOR Donaldson Funeral Home ADDRESS Laurel, Maryland

RECEIVED
JAN 19 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00148

CERTIFICATE OF DEATH

Reg. Dist. No. 22

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural - Laurel | LENGTH OF STAY (In this place) 2 yr 7 mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Destruct Training School

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE D.C. COUNTY —
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington
STREET ADDRESS (If rural give location) 2317 Ontario Rd. N.W. ✓

3. NAME OF DECEASED (Type or Print): (First) Donald (Middle) Helm (Last) Walker

4. DATE OF DEATH: (Month) Jan (Day) 8 (Year) 1950

5. SEX: M | 6. COLOR OR RACE: C | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): S | 8. DATE OF BIRTH: 7-19-37 | 9. AGE last birthday: 12 yrs. | If under 1 year: Months 5, Days 20 | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none | 10b. KIND OF BUSINESS OR INDUSTRY: none | 11. BIRTHPLACE (State or foreign country): Washington, DC | 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Helm

14. MOTHER'S MAIDEN NAME: Matsue Walker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. |

17. INFORMANT: RDHUFF by Social Records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Rheumatic Fever — Interval between onset and death: 5+ days

400X

Antecedent cause(s)

58e

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Mental Deficiency — Birth

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-28, 1947, to 1-8, 1950, that I last saw the deceased alive on 1-7, 1950, and that death occurred at 12[15] A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Richard D Huff M.D. ADDRESS Laurel maryland DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) | DATE 1-10-1950 | NAME OF CEMETERY OR CREMATORY Dist Training School | LOCATION (City, town, or county) Laurel, Anne Arundel Co Md (State)

DATE REC'D BY LOCAL REG. 1-9-50 | REGISTRAR'S SIGNATURE Elara Haslup | 24. FUNERAL DIRECTOR Wm Kenneth B Jones ADDRESS

XUX64

RECEIVED
FEB 2 1950
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH

00149

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN (RURAL) Severn — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Quarterfield Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY A.A.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pasadena P.O.,
STREET ADDRESS (If rural, give location) 4th St., Green Haven.

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	OTIS	WALTON	JANY	21	1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Married	Oct. 14, 1922	27 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Fertilizer
11. BIRTHPLACE (State or foreign country): Irvington, Virginia.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James Henry Walton
14. MOTHER'S MAIDEN NAME: Corinne Ashburn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII WWII
16. SOCIAL SECURITY NO.: 219-18-5476
17. INFORMANT: Ernest W. Vogel, Green Haven Pasadena, P.O. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Fractures of Skull, neck and chest	Instt
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Automobile overturned	
	(c)	

821.5
1700

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE OF INJURY (Home, farm, factory, street, department, etc.): Quarterfield Rd — (CITY OR TOWN) Severn — (COUNTY) A.A. — (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Jany 21, 1950 10½ p m. — INJURY OCCURRED While at work ☐ Not while at work ☑ — HOW DID INJURY OCCUR? Automobile Overturned

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE — (Degree or title) — ADDRESS — DATE SIGNED
John M. Coffey M.D. Deputy Medical Examiner Annapolis Md 1/22/50

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 24, 1950 — NAME OF CEMETERY OR CREMATORY: Mt. Carmel, A.A. County — LOCATION (City, town, or county) (State): Mountain Road, Pasadena, Md

DATE REC'D BY LOCAL REG. 1/23/50 — REGISTRAR'S SIGNATURE: L. J. Dallam

24. FUNERAL DIRECTOR — ADDRESS: Thomas W. Singleton, Glen Burnie, Md.

988-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

RECEIVED
JAN 24 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00150

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis, Maryland
LENGTH OF STAY (in this place) 18 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS USNH, Annapolis, Maryland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE California; COUNTY Los Angeles
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Los Angeles
STREET ADDRESS (If rural, give location) 3015 Leeward Avenue

3. NAME OF DECEASED (Type or Print): (First) Cordelia; (Middle) (none); (Last) WATERS

4. DATE OF DEATH: (Month) January; (Day) 14; (Year) 1950

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 4-6-1867

9. AGE last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset and Death: 19 days

420.0 Antecedent cause(s)

93d Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic Heart Disease with Hypertension — Years

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-27, 1949, to 1-14, 1950., that I last saw the deceased alive on 1-14, 1950., and that death occurred at 4:05 A. m., from the causes and on the date stated above.

SIGNATURE: G.M. Davis
(Degree or title): Commander, MC, USN
ADDRESS: USNH, Annapolis, Maryland
DATE SIGNED: 1-14-50

23. ~~BURIAL, CREMATION~~ REMOVAL (~~Specify~~) — DATE: 1-17-1950 — NAME OF CEMETERY OR CREMATORY — LOCATION (City, town, or county) (State): LOS ANGELES CALIF.

DATE REC'D BY LOCAL REG.: Jan. 16, 1950

REGISTRAR'S SIGNATURE: W. T. Couch

24. FUNERAL DIRECTOR: John M. Taylor Son — ADDRESS: Annapolis Md.

RECEIVED
JAN 17 1950
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

00151

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 21

1. PLACE OF DEATH: COUNTY Anne Arundel; MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Mill Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY A.A.; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Arnold; STREET ADDRESS (If rural give location) Old Mill Road

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) ALVERTA (Last) WATTS

4. DATE OF DEATH: (Month) JANY (Day) 7 (Year) 1950

5. SEX: FEMALE

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Mar. 10 1910

9. AGE last birthday: 39 yrs. If under 1 year: Months; Days; If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: George Gray

14. MOTHER'S MAIDEN NAME: Francis Stewart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Samuel Watts

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Post-partum Hemorrhage

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (unattended during labor and birth.)

(c)

678X

1490

Coded & changed on Auditor's Office of Mat. Hyg. Committee

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from, natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

John M. Duffy M.D. Deputy Medical Examiner Annapolis Md 1/7/50

23. BURIAL, CREMATION, REMOVAL (Specify) Burial; DATE THEREOF Jan. 10, 1950; NAME OF CEMETERY OR CREMATORY Mt. Calvary; LOCATION (City, town, or county) (State) Arnold, Md

DATE REC'D BY LOCAL REG. Jan. 10, 1950; REGISTRAR'S SIGNATURE W. French

24. FUNERAL DIRECTOR ADDRESS J.B. Johnson, Annapolis, Md.

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

RECEIVED
JAN 11 1950
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00152

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH — COUNTY: Anne Arundel — MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Balti City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Crownsville — LENGTH OF STAY (in this place): 3 yr. 2 days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Crownsville State Hospital	STREET ADDRESS (If rural, give location): 861½ Fairmount Avenue

3. NAME OF DECEASED (Type or Print)	(First) Julius	(Middle)	(Last) White	4. DATE OF DEATH	(Month) 1/29/50 (Day) (Year) 19
5. SEX: male	6. COLOR OR RACE: colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: not known	9. AGE last birthday: 66(?) yrs.	If under 1 year: Months. Days; If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer	10b. KIND OF BUSINESS OR INDUSTRY: none	11. BIRTHPLACE (State or foreign country): Virginia	12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME: William White	14. MOTHER'S MAIDEN NAME: Lu Davis				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS: Hospital Records			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cancer of Stomach	known since ~~Nov. 27/~~ 1949
151 × Antecedent cause(s)		
46 b Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) Senile Psychosis	known since ~~1/27/47~~

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none	19b. MAJOR FINDINGS OF OPERATION: none	20. AUTOPSY? Yes ☒ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify): no	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour): none m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR? none

22. I hereby certify that I attended the deceased from 1/27/47, 19....., to 1/29/50, 19....., that I last saw the deceased alive on 1/29/50, 19....., and that death occurred at 7:40 Aa m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Jacob Morgenstern M.D.		Crownsville, Maryland	1/29/50

23. BURIAL, CREMATION REMOVAL (Specify): burial	DATE: 2/1/50	NAME OF CEMETERY OR CREMATORY: Mt. Brown	LOCATION (City, town, or county) (State): Baltimore, Md.
DATE REC'D BY LOCAL REG.: 2/3/50	REGISTRAR'S SIGNATURE: H.W. Hedrick Dr.	24. FUNERAL DIRECTOR: Mrs. Katie Williams	ADDRESS: Balti. Md

98899

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00153

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH
COUNTY: Anne Arundel — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fort Geo G Meade
LENGTH OF STAY (in this place): 3 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Station Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Pennsylvania — COUNTY:
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cardale
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) (NONE) (Last) YACOBET

4. DATE OF DEATH: (Month) January (Day) 13 (Year) 1950

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Married	12 October 06	43 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife		Pennsylvania	USA

13. FATHER'S NAME: James Gentile

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs Rose Mitchell, Ft Meade Cabins # 7 Odenton, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Uremia

593 Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 132 (b) Nephritis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 10 Jan, 1950, to 13 Jan, 1950, that I last saw the deceased alive on 13 Jan, 1950, and that death occurred at 0615 a.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title) ADDRESS	DATE SIGNED
Frank Thaman Jr	Capt., Mc. Sta Hosp Ft Geo G Meade, Md	13 Jan 50

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	13 Jan 50	Unknown	Republic, Pennsylvania

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
13 Jan 50	JAMES E. HAYES, Capt. MSC	DONALDSON Funeral Home, Laurel, Md.	

RECEIVED
JAN 16 1950
BUREAU V. S.